Meds by Mail

a mail order prescription service for qualified CHAMPVA beneficiaries

Order Form

Please see the reverse side for Meds by Mail mailing addresses

New Prescriptions and/or Initial Orders Only

CAUTION: Do NOT postpone taking prescribed medications! Since your Meds by Mail delivery can take up to 21 days from the date you mail your order, have your physician write two (2) prescriptions–one to be FILLED IMMEDIATELY by your local pharmacy and the other to be MAILED IMMEDIATELY to Meds by Mail with a completed Order Form. To help ensure that there is no medication interruption while awaiting your Meds by Mail shipment, make sure that the local pharmacy prescription is adequate for at least a 30-day supply.

INSTRUCTIONS: This Order Form is to be completed by the beneficiary/family member (NOT the prescribing physician) for NEW maintenance prescriptions only (such as those required for extended periods of time). To order REFILLS on previously filled Meds by Mail prescriptions, see the below instructions–do NOT use this Order Form. While this form is designed to handle multiple prescriptions, it is limited to one beneficiary only–a separate Order Form is required for each additional Meds by Mail family member. To place an initial order, simply send the following to the ABOVE address (do NOT send orders to VA's Health Administration Center in Denver):

1) the original prescription (no copies) with the prescribing physician's Drug Enforcement Agency (DEA) number (limited to a 90-day supply plus refills–not to exceed one (1) year); and
2) a completed *Meds by Mail Order Form*

Refill Orders

Instead of using this Order Form which is designed exclusively for NEW prescriptions, refill orders are placed using the ***refill slip*** that accompanies all prescriptions that have refills remaining. Refill orders must be placed using this refill slip–***telephone orders are NOT accepted***. To ensure timely delivery, return your refill slip as soon as possible but no later than 21 days before needing the refill.

Patient/Prescription Information

(please PRINT information below and attach the original prescription for each medication requested)

Beneficiary Name (Last, First, MI)	Beneficiary SSN	Date of Order

Prescription	Medication Name	Physician Name
1		
2		
3		

(continue on back if necessary)

Mailing Information

(indicate where the prescriptions are to be mailed–please PRINT)

Name	Day Phone No. ( )

Address ☐ check if new

For additional Order Forms you may either photocopy a blank form or call VA's Health Administration Center at 1-800-733-8387, between the hours of 7:30 a.m. to 11:30 a.m. (Mountain Time), Monday through Friday (holidays excluded). If page 2 is photocopied, please ensure that it's either on a two-sided copy (page 1 on front) or ATTACHED to page 1.

Meds by Mail

Order Form

Page 2

West

If you live in one of the following states please mail your order form to the address listed below:

Alaska, Arizona, Arkansas, California, Colorado, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Texas, Utah, Washington, Wisconsin, Wyoming.

address: Meds by Mail
PO Box 20330
Cheyenne WY
82003-7008

telephone: 1-888-385-0235

East

If you live in one of the following districts, states or territories please mail your order form to the address listed below:

Alabama, Connecticut, Delaware, Florida, Georgia, Kentucky, Maine, Maryland, Massachusetts, Mississippi, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, Washington D.C., West Virginia.

address: Meds by Mail
VISN 7/Dublin
PO BOX 9000
Dublin GA
31040

telephone: 1-866-229-7389

(continued from front page)

If this page is photocopied, please ensure that it's either on a two-sided copy (page 1 on front) or ATTACHED to page 1.

Patient/Prescription Information

(limited to prescriptions for the beneficiary identified on front)

Prescription	Medication Name	Physician Name
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
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16		
17		
18		
19		